EXHIBIT FF

Response to Unsolicited Question
ACTG 5142

1	Focus on Data	• Kaletra SGC BID vs Sustiva QD (open label study) • All treatment regimens were potent • The increase in CD4+ cell count was greatest in the 2 Kaletra arms • Both Kaletra and Sustiva are the only PI and NNRTI DHHS Preferred ARVs • Regimens were equally well tolerated • Preliminary resistance data: No major PI Mutations in Kaletra ARM vs. NNRTI resistance in Sustiva arm with statistically more multi-class resistance
2	Kaletra SGC vs Tabs	• Kaletra QD Tablets and BID Soft Gel Caps are different formulations and no longer marketed in the United States • Kaletra tablets provide reduced pill count, reduced PK variability, no refrigeration, no food requirements and fewer excipients.
3	Review use of Kaletra first - Core Strengths that matter vs. Sustiva	• Resistance • Safety • Immune response

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Doctor: *I recently read that a Sustiva based regimen had a higher proportion of patients <50 copies (undetectable) compared to Kaletra. The data also noted that a Kaletra based regimen had a high rate of gastrointestinal (GI) adverse events compared to Sustiva.*

Representative Response: *This open label study used Kaletra capsules. Kaletra Tablets offer patients QD dosing, reduced pill count, reduced PK variability, and no food requirements. Despite differences, all of the treatment regimens were potent – for all three arms combined, the percentage of participants with viral load undetectable (less than 50 copies) was 83% after 2 years.*

This shows why both Kaletra and Sustiva are the only DHHS Preferred PI and NNRTI ARVs in initial combination HIV therapy. According the DHHS Guidelines there are several Factors to consider when selecting an initial regimen some of which include: results from genotypic drug resistance testing. In 4 clinical trials raning from 48 to 204 weeks, primary resistance to Kaletra has not yet been characterized, and Kaletra is pregnancy category C drug. Based on these recommendations which patients new to therapy do you feel are better candidates for a Kaletra vs Sustiva based ARV regimen?

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Doctor: *What can you tell me about the most recent published data between Kaletra and Sustiva?*

Representative Response: *This study was open label and used Kaletra capsules. Kaletra Tablets offers patients QD dosing, reduced pill count, reduced PK variability, and no food requirements. Despite differences, all of the treatment regimens were potent – for all three arms combined, the percentage of participants with viral load undetectable (less than 50 copies) was 83% after 2 years.*

Doctor based on this data, have you learned anything new about Kaletra or Sustiva? In your clinical experience have you seen a difference in how these two DHHS Preferred ARVs perform for your ARV Naïve patients? In your experience, which patients do better with Kaletra vs. Sustiva as the initial ARV?

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One area of this study that I thought was interesting is the prevalence of resistance. For Kaletra this study once again showed no major PI mutations and only a small number of NRTI mutations developed in this ARV naïve patient population. This was statistically different from the Sustiva Arm which showed more patients developing NNRTI and NRTI mutations, which lead to a higher percentage of patients with mutations in 2 classes. Additionally, 4 clinical trials with Kaletra ranging from 48 to 204 weeks did not show any primary resistance to kaletra.

Doctor, based on Susan Little's data (page 12 sales aid) baseline NNRTI resistance is on the rise as a result of transmitted drug resistance. We know based on Borroto-Esoda's data (page 13 sales aid) initiation of ARV therapy is 10 times more likely to fail with a baseline NNRTI (K103N) mutation. How does this data play in your initial ARV choice between Kaletra and Sustiva? Do you obtain baseline genotypic information prior to initiating ARV therapy?

Finally doctor let me focus on utilizing Kaletra ..specifically as it pertains to resistance development in naïve patients……The DHHS recommends a Kaletra-based regimen as initial therapy in ARV naïve patients. Do you have patients who may benefit from this strategy?